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ABSTRACT

In view of recent studies of media use in mental hospitals showing that television is the predominant mass medium and one with great potential for therapy, a study was conducted to determine the patterns of television viewing in this environment. A total of 1,204 observations were made in five lounges on two wards of a mental hospital. Correlational analysis was used to determine the relationship of those viewing patterns to the patterns of other mass communication, interpersonal communication, and intrapersonal communication activities also taking place. The results indicated that there were certain structural forces, including scheduling of hospital activities and patient participation, that operated in the hospital to determine the patterns of these activities. Implications for the therapeutic use of television in the mental hospital include taking advantage of existing programing to teach patients how to watch television effectively, and developing therapeutic television programing using videocassettes and cable television. (DF)

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THE DETERMINATION OF TV VIEWING PATTERNS IN A MENTAL HOSPITAL AND COMMENT ON THERAPEUTIC APPLICATIONS OF THIS "CONSTANT COMPANION."

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ABSTRACT

THE DETERMINATION OF TV VIEWING PATTERNS IN A MENTAL HOSPITAL AND COMMENT ON THERAPEUTIC APPLICATIONS OF THIS "CONSTANT COMPANION."

By

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During the last three years a series of studies has been conducted to investigate how the mass media are used in mental hospitals. The conclusions that can be drawn from the results of these studies are (1) television is the predominant mass medium in the mental hospital and (2) television has great potential as a therapeutic tool in the mental hospital. In this study a data base of 1,204 observations of five lounges on two wards of a midwestern mental hospital is used by investigators to determine the patterns of television viewing in this unique environment. Furthermore, the investigators use correlational analysis to determine the relationship of those viewing patterns to the patterns of other mass communication, interpersonal and intrapersonal activities taking place at the same time. The results indicate that there are structural forces operating in the hospital to determine the patterns of these activities. The identities of these factors are suggested and a comment is made on the general categories of any potential television therapy, on which patients might benefit most from such therapy and on when such therapy might be introduced into the daily and weekly routine of the mental hospital.

INTRODUCTION

For the past three years a series of descriptive and exploratory studies of the relationship between the mass media and mental illness have been conducted in several locations in the United States. In spite of the fact that these studies have used different methodologies and overall approaches, their goal has been the same--to shed light on this previously neglected research area and, more importantly, to provide a foundation for the development of therapeutic procedures involving the mass media and the mentally ill.

Using a "case study" approach involving a "typical" mid-western mental hospital in Illinois, Jeffers, Ostman and Atkinson (1977a; 1977b; 1979) sought to answer two basic questions. First, what mass media are available to those hospitalized in a mental institution, and second, how do patients use the mass media available to them?

To answer these questions the investigators gathered descriptive data on all media items (such as TVs, radios, magazines, journals, books, newspapers, pamphlets and catalogs) located throughout two hospital wards. Then, using observational techniques, they concentrated on the lounges of the same wards to gather descriptive data on how patients used both broadcast and print media. Furthermore, they gathered data on other frequent lounge activities, such as talking, and playing games.

Following their studies they concluded that, except for television viewing, there was very little mass media use by patients on the mental hospital ward. There was virtually no radio listening and practically no reading in the lounges. This conclusion was reached in spite of the fact that a relatively large number of print media items was found in the ward lounges.

Jeffers et al. say that because of the apparent lack of a variety of mass media use in the mental hospital it would be easy to conclude that the mass media are not very important to the mental patient. However, they point out that looking at other activities that take place in the wards and lounges helps to put media use in this unique setting in perspective. They found that nearly half of the non-media activities in the lounges involved such dysfunctional things as sleeping. They conclude, "If the patients were not reading magazines, newspapers, and books or listening to the radio, they were not doing much else in the lounges either--except watching television" (Jeffers, Ostman, & Atkinson, 1977b p 203).

In a study that sought to answer many of the same questions as the research cited above, but which focused only on television viewing behaviors of mental patients, Rubinstein, Fracchia, Kochnower and Sprafkin (1977) arrived at many of the same conclusions reached by the other researchers.

Using a methodology that was completely different than that employed by the Jeffers, et al. studies (a questionnaire that was completed by psychiatric center directors and ward staff concerning the TV behaviors of patients in 18 New York state mental hospitals) the Rubinstein team (1977) concluded that "center directors generally believed television's impact upon institutionalized patients has been positive and that television viewing may have potential as a therapeutic procedure in mental hospitals." (Rubinstein et al. 1977, p ii) Furthermore, they noted that television viewing was reported by those completing the questionnaire to be a "pervasive behavior" which in the staff's opinion helped create a better environment for many patients.

In another study that focused exclusively on television viewing of mental patients, but was also a product of the "case study" approach in Illinois, Collett and Larsen (1977) found support for the notion that TV viewing could be a positive experience in the mental hospital. They had hypothesized that TV viewing would deter interpersonal relationships among patients, but were surprised to find evidence to suggest just the opposite. For instance, they found that when interpersonal conversation did occur it was most likely to be when the television set was on.

In a paper that directly compares the results of the two very different methodological approaches to investigating mass media behavior in the mental hospital (case study in Illinois, survey in New York), Ostman, Jeffers and Atkinson (1978) demonstrate that there is a high degree of similarity in the findings of the two approaches and present eleven conclusions regarding mass communication, interpersonal and intrapersonal activities taking place in the mental hospital that would seem to have a great deal of generalizability.

There have been several other studies which have focused on much more specific research questions involving the mass media and the mental patient. Fowler (1977) sought to investigate how mental patients use a hospital library to obtain reading materials (books, magazines, and so on). He concluded that, in general, patients who were frequent users of a library prior to being hospitalized are most likely to use a library to obtain reading material while at the hospital.

Another study, one that suggests that patient mass media use may be less than positive, was conducted by Ostman, Smith, Jeffers and

Atkinson (1978). They investigated the utility of the mass media for mental patients by looking for significant differences between mental patients' and university students' perceptions of personal applicability of 25 mass media functions and dysfunctions. Their results indicated that there may be harmful "effects" caused by dysfunctional media use by the mental patients. Furthermore, they speculated that dysfunctional media use by mental patients may have played a role in making them less able to function in the non-institutionalized setting.

From the above brief review of the research done to date on this topic, it is clear that researchers have made progress in describing the total mass media situation inside mental hospitals. Furthermore, those who have completed research in this area are even more convinced of the importance and legitimacy of this line of inquiry. But the most important conclusions that can be drawn from the above review are two. First, mass communication researchers, as well as mental health clinicians, are convinced that the mass media have great potential for therapeutic use in the mental hospital. Second, television is the dominant medium of mass communication in the mental hospital, and as such, at this point in time anyway, deserves the greatest attention from researchers.

This concern for the therapeutic use of television is best expressed by the Rubinstein team when, in the conclusion of their study. they say.

> If television violence is an environmental hazard for individuals in a home-viewing situation, how much more of a hazard might it be for populations at greater risk, particularly those in institutional settings? The question has even more important implication for patients in psychiatric centers, from which our findings derive.

> Beyond the possible harmful effects, we should be especially desirous of finding out how television viewing can contribute in a more positive way to the total therapeutic environment of that institutional setting. We believe such research will be an important next step, not only because of the potential benefit to the individuals involved, but because the information obtained will add to our basic understanding of how television affects all of us. (Rubinstein, Fracchia, Kochnower, & Sprafkin, 1977, pp 32-33)

RESEARCH QUESTIONS AND PURPOSE OF THIS PAPER

In spite of the fact that researchers have made progress in describing the mass media situation in mental hospitals, there is still a great deal of information about this unique environment that needs to be obtained before specific therapeutic programs can be formulated.

For instance, in spite of the fact that prior research indicates that television is the "dominant medium" and that its use in a mental hospital is "pervasive," researchers still do not have a clear picture of when television is used in the mental hospital. For example, other than for looking at differences among very gross time periods (such as morning, afternoon, evening, etc.) none of the previous research has addressed the question of how might television viewing vary during the "institutional" day. Furthermore, are there differences in viewing patterns from day to day? It seems reasonable to speculate that the institutional "weekday" would provide different viewing opportunities than the institutional "weekend" when most organized activities cease.

Also, what is the relationship of television viewing in the mental hospital to other activities that are taking place at the same time? This is a particularly important question because, as the results of previous research show, television viewing takes place in a "public area." This can be a dayroom, lounge or reception area and because of the limited amount of space in institutional facilities there are a number of other purposive and non-purposive activities taking place in addition to TV viewing. Unfortunately, aside from a few tentative conclusions reached by previous researchers, there is very little information to guide those interested in developing therapeutic programs involving television that will best fit the "total environment" in the mental hospital.

A focus on the variations of television viewing in a mental hospital and that viewing's relationship to other activities necessarily requires further descriptive analysis. Nevertheless, investigation of these two concerns can help researchers gain a better understanding of the social, structural and cultural forces that are operating in this particular setting to help determine media consumption.

Indeed, as a number of mass communication theorists have pointed out, a concern with these social, structural and cultural variables has been a dominant theme in much mass communication audience research and that, furthermore, there should be a continued emphasis on the investigation of these phenomena. McQuail and Gurevitch (1974) explain that research which focuses on media use in the context of specific societal settings (such as in a mental

hospital) is particularly valuable because such research helps increase our "awareness of the force of custom and habit and of the fact that definitions of appropriate behavior are built into such patterned social activities." (McQuail & Gurevitch, 1974, p 293)

While the "structural/cultural perspective" outlined by McQuail and Gurevitch suggests that audience orientations are responsible for only a part of mass communication behavior, those who have focused mainly on audience orientations as primarily being responsible for mass communication behavior have not slighted the impact of social structure on the development of those orientations. For instance, in their article that summarizes the theoretical and methodological concerns of "uses and gratifications" research, Katz, Blumler and Gurevitch (1974) discuss the social origins of audience needs and their gratifications. They note that the social and environmental factors which lead people to turn to the mass media for satisfaction of certain needs are not very well understood and that further research is needed in this area.

In essence then, it is important to gain a clearer understanding of television viewing patterns and the relationship they may have with other activities taking place in the mental hospital in order that researchers can acquire additional knowledge of the social and structural forces operating in this unique environment.

Consequently, the specific research questions explored in this paper are:

1. Given that television viewing is the dominant activity in the mental hospital lounge or dayroom, what are the patterns

of television viewing throughout the typical institutional week and during the typical institutional day?

2. How do these patterns of television viewing compare with the patterns of other activities that are taking place in the lounge or dayroom throughout the typical institutional week and during the typical institutional day?

Furthermore, while no specific research question has been formulated, an additional purpose of this paper is to draw on the results of this study, as well as the previous research, and move beyond the conclusion that television has potential therapeutic value in the mental hospital and comment on issues relevant to the development of such programs.

RESEARCH SETTING AND METHODOLOGY

To answer the specific research questions of this paper further analysis of the observational data gathered by Jeffers, Ostman and Atkinson (1977b; 1979) was performed. These data were gathered at the Anna Mental Health and Developmental Center in Illinois--one of 26 such state-supported centers designed to treat patients on a residential basis. Jeffers, et al. believe data gathered in this setting have a great deal of generalizability because, while there may be some variation in mass media-related situational factors, it is assumed that the variation will be at a minimum in state-supported institutions. Indeed, this seems to be the case because, as noted earlier, a direct comparison of the Illinois data with data representing the media situation in 18 New York state mental hospitals showed a high degree of similarity in findings.

The original data collection procedure yielded 1,922 separate observations of eight lounge areas on two different wards for a constructed week developed from a three-week period in March and April, 1977. The method of observation was structured, using a sign system checklist and a time-sampling procedure for determining when the observations should be made.

Observers visited the lounge areas once every half hour from approximately 5 AM (when patients begin to awake) to approximately 11 PM (when all but a very few patients have gone to bed) and gathered data on 49 different variables. The researchers classified these into four general categories: First, reference variables such as time of day and number of persons in the lounge; second, broadcast media variables such as number watching television and program choice; third, print media variables such as number reading newspapers, books, and magazines; and fourth, non-mass communication variables that occurred with great regularity in the lounges, such as talking, listening and playing games. The frequency distributions for the number of observations involving each of these variables have been reported previously (Jeffers, Ostman & Atkinson 1977b; 1979).

This data base, as opposed to the Rubinstein team's data base for instance, is particularly appropriate for investigating the research questions. First, these data provide a count of the number of persons viewing television throughout the institutional day and for each day of the institutional week. Second, these data also provide a count of the number of persons engaged in other purposive and non-purposive activities taking place at the same time as the television viewing. Having these measures allows for

a comparison of television viewing with the various types of activities.

Answering the specific research questions of this paper required some modifications and reconceptualization of the variables contained in the original data base, however. The original data base contains information gathered by observations of eight lounge areas--three of these areas did not have television sets. Consequently, because this study focuses on television viewing, only those observations gathered in the five TV lounges were analyzed. Therefore, the total N is reduced to 1,204 observations over the three-week period.

The most important modification of the original data base involves a reconceptualization of the variables concerned with non-television viewing activities. In the first reports of their study, except for the grouping of like mass communication variables (such as broadcast and print), Jeffers et al. made it clear that they were gathering data on variables for descriptive and exploratory reasons. As such, the list of non-mass communication variables to be observed was developed on the basis of a series of pre-test observations which indicated these activities regularly took place in the lounge. No attempt was made to categorize or classify these non-mass communication variables into larger theoretical groupings. However, because the focus of this paper is on the variations in TV viewing and its relationship to the other activities going on at the same time, it is important to group these activities in a way that provides a better understanding of the social/structural nature of the setting.

Consequently, for this paper, all variables that represent non-television viewing activities are first combined to provide a measure of all other activities taking place in the lounge to which TV viewing might be compared. This classification is titled All Non-TV Activities. Then, each of the non-mass communication variables is assigned to one of three broad classifications that represent social-structural activities taking place in the lounges to which television viewing might be compared. These are:

Interpersonal Activities--These are activities in which two or more residents are involved and are considered to be "positive" because a goal of much therapy is to help the resident develop interpersonal relationships. The activities included in this category are talking and listening to each other, playing cards or other games with others, playing pool, playing the piano for others and taking drugs or other medication.

Active, Functional Intrapersonal Activities--These are activities that the resident engages in alone, but nevertheless, are still considered "positive" because of their pro-social nature. Activities included in this category are reading and writing letters, drawing and working at crafts.

Passive, Dysfunctional Intrapersonal Activities--These are activities that have been defined as "negative" or "pathological" by mental health clinicians and, depending upon the orientation of the hospital, may or may not be discouraged. The activities in this category are sleeping, pacing and sitting or standing doing nothing in particular.

Also, because no radio listening was observed in any of the TV lounges all non-TV viewing mass communication variables could be classified as print media related. Consequently, a fourth classification was developed:

Reading--This included the reading of magazines, pamphlets, catalogs, books and newspapers.

To chart the variation in numbers of persons watching television in the lounge areas by hour of the day and day of the week (in order to answer the first research question), it was necessary to calculate a measure of central tendency of that number for each hour of a composite day and each day of a composite week. When first reporting the frequency distribution of the observations involving the variables in the original data base, Jeffers, et al. noted that the distributions were skewed, and as a result, reported medians rather than means as the best measure of central tendency. Likewise, the median was chosen as the best measure of central tendency for this data analysis.

In order to answer the second research question, medians for each of the five other groups of variables (All Non-TV, Reading, Interpersonal, Functional Intrapersonal and Dysfunctional Intrapersonal) were computed for each hour and day in order to determine patterns in the number of persons engaged in those activities as well.

The medians reported in this analysis need to be interpreted in light of how the data were collected. The observational process resulted in an average of nearly 70 observations of the five lounges for each hour. Therefore, unless an activity was almost constantly taking place, the high number of observations has the effect of

making the modal number of persons observed participating in that activity zero. Naturally, this depresses the other measures of central tendency as well. And in fact, as noted earlier, Jeffers et al. indicated television viewing was the only activity that could be considered "constant." Therefore, the medians for all other activities are likely to be very low.[1] This does not prevent us from examining these medians for trends and patterns, but the low medians may mask the fact that much larger numbers of persons occasionally participate in these non-constant activities. Consequently, the range of the number of persons engaged in TV viewing and of all activities taken together and each of the social-structural variable clusters for each hour and each day also is reported.

Also, to provide some additional information useful in answering the second research question, a correlational analysis of a portion of the data was completed. First, a Spearman Rank Correlation Coefficient was computed for the daily and hourly medians of number of persons watching television and the daily and hourly medians of number of persons engaged in all other non-TV viewing activities. This provides a measure of the relationship between television viewing and the other lounge activities. Then a matrix of Spearman Rank Correlation Coefficients for the daily and hourly medians for TV viewing, Reading, Interpersonal activities, Active, Functional Intrapersonal activities and Passive Dysfunctional Intrapersonal activities was created. This provides a measure of the relationship between TV viewing and each of the four

social-structural variable clusters as well as a measure of the relationship of each variable cluster to the others. In other words, these correlation coefficients can tell us if the number of persons watching TV co-varies in a consistent manner during the week and during the day with the number of persons engaged in any or all of the social structural variable clusters.

RESULTS

The data needed to answer the first research question (what are the daily and weekly television viewing patterns in a mental hospital) can be found in Table 1. The television viewing pattern for the "typical" week in the hospital is as follows: After attaining a relatively high level on the weekend, the median number of persons watching TV begins to decline on Monday, takes a sharp drop on Tuesday, a sharp upturn to peak on Wednesday, declines again on Thursday but begins a gradual increase on Friday toward the level for Saturday and Sunday.

The television pattern for the "typical" day in the hospital is as follows: There is a period when the median is at a relatively low level between 5 and 8 AM. This is followed by an hour between 8 and 9 AM when the median is relatively high. The median number of persons viewing TV then declines to its previous level for the next two hours until 11 AM when, until Noon, it takes a sharp drop. For the next two hours (between Noon and 2 PM) the median number of TV viewers is similar to that found during most of the morning. However, starting at 2 in the afternoon, the median number of persons watching TV begins to increase to the day's peak, which is reached during the hour between 4 and 5 PM. Between 5 and 6 PM there is

a sharp drop, but, beginning at 6 PM and lasting until 10 PM there is a period when the median is relatively high although the hour between 8 and 9 PM is a time of slight decline. The median number of viewers between 10 and 11 PM is similar to those found in the early morning hours.

A portion of the data needed to determine how these patterns compare with the patterns of other activities taking place in the hospital lounges (The second research question) can also be found in Table 1. The weekly pattern for all non-TV viewing activities is like this: Following two days of being at a relatively moderate level on the weekend, the median number of persons engaged in these activities increases on Monday and Tuesday, then reaches a peak on Wednesday. The median number declines on Thursday and falls to the weekly low point on Friday. The median number then increases to the moderate level for Saturday and Sunday.

Information on how the social-structural variable clusters relate to television viewing for the week can be found in Tables 2 and 3. When all variable clusters are combined to form the All Non-TV Activities scale there is no significant association with television viewing (Spearman=.07, NS). However, when this scale is divided into the social-structural clusters the results indicate that Active, Functional Intrapersonal activities are negatively correlated with television viewing. This means that on days when the median for the total number of persons watching television is large, the median for the total number of persons reading and writing letters, drawing and working at crafts is small and vice versa.

Highlights of the weekly patterns for each of these social-structural variable clusters follow: Sunday and Monday are the days when the largest median numbers of persons were observed reading. No one was observed reading on Tuesday. The median number of persons engaged in Interpersonal activities is higher on Monday and Tuesday than at other times of the week. Friday has the smallest median number of persons participating in these activities. Monday, Tuesday, and Saturday are days when the median for those taking part in the Active, Functional Intrapersonal activities is highest. Sunday has the lowest median for persons participating in this category. Sunday, Monday and Tuesday have the highest median number of persons engaged in the Passive, Dysfunctional Intrapersonal activities.

Data needed to determine the daily pattern of all non-TV viewing activities can be found in Table 1. This pattern is as follows: There is really no activity until 7 AM when the median number of persons engaged in these non-TV viewing activities begins to increase to a morning high between 10 and 11 AM. Then, between 11 AM and 1 PM the median drops to a relatively moderate level. During the afternoon, between 1 and 5 PM, the median fluctuates every other hour between a peak value and a moderate value. Between 5 and 6 PM the median number of persons engaged in these activities drops to a low level. Between 6 and 8 PM the median is at a moderate level. Between 8 and 9 PM the median peaks for the evening, and, starting at 9 PM, declines so that between 10 and 11 PM the median is close to that level found at the beginning of the day.

Information on how the social-structural variable clusters relate to TV viewing during the day can be found in Tables 2 and 4. The

correlational analysis shows that there is no relationship between the hourly TV viewing pattern and the hourly pattern of persons engaged in all non-TV viewing activities (Spearman=.14, NS). The results for the correlational analysis for the social-structural variable clusters show that none of these scales are associated with television viewing. However, what little reading is taking place is positively correlated with the Interpersonal and Active, Functional Intrapersonal activities. The hourly median for the number of persons engaged in Interpersonal activities is also positively correlated with the median for the number of persons engaged in Passive, Dysfunctional Intrapersonal activities.

Highlights of the daily patterns of the social-structural variable clusters follow: The median number of persons observed reading attains its highest levels between Noon and 4 PM, indicating that reading is primarily an afternoon activity in the hospital. At 8 AM the median number of persons engaged in Interpersonal activities attains a level that remains fairly constant thorughout the day until 10 PM. The only real fluctuation comes at 5 PM when the median drops for an hour. There are three times during the day when the median number of persons engaged in the Active, Functional Intrapersonal activities reaches relatively high levels. These are 5 to 6 AM, 1 to 3 PM and 8 to 10 PM. The median number of persons engaged in the Passive, Dysfunctional activities is high for two 3-hour periods which amount to the bulk of the morning and afternoon. The first period runs from 8 to 11 AM and the second runs from 2 to 5 PM. The hour between 8 and 9 AM has the highest median for the number of persons engaged in these activities.

DISCUSSION

These results demonstrate there are variations in patterns of television viewing and other activities in the hospital lounges. We can assume there are social and structural forces operating in the mental hospital to determine these patterns. While the correlational analysis indicates that, for the most part, there is no consistent relationship between TV viewing and the other activities taken as a whole or in clusters, a comparison of the patterns of the different activities at certain times of the day and week may help identify those forces.

The social-structural forces operating to create the hourly patterns seem easier to discern than the forces creating the daily patterns. For instance, it is not surprising to find that the daily medians for television viewing and all other activities are both relatively high on the weekend. After all, most day shift staff in charge of educational and therapeutic programs are off, and as a consequence, more patients have more time to spend in the lounges. However, what is surprising is the fact that Wednesday has the highest median number of television viewers of any day of the week. Furthermore, Wednesday has the highest median number of persons engaged in all other activities as well.

Also, Mondays and Tuesdays are unique days in the mental hospital. On those days the median number of persons watching TV is at its lowest point for the week. However, on those days the medians for the number of persons engaged in Reading, Interpersonal, Active Functional Intrapersonal and Passive Dysfunctional Intrapersonal activities reach high levels.

There clearly seem to be some structural factors operating to make Wednesday the most "popular" day for engaging in all lounge

activities (including watching TV) and at the same time operating to depress television viewing on Monday and Tuesday while encouraging participation in the other lounge activities. This pattern may be at least partially explained by the hospital's weekly schedule of evening recreational activities. On Tuesday, Thursday and Saturday nights the hospital has planned evening activities that might attract patients who would otherwise spend time in the lounge watching television. The fact that Wednesday night is an "open" night in terms of planned activities may account for the fact that it is the day of the week that has the highest median number of persons engaged in all types of activities in the lounges. However, further research is needed to substantiate this explanation.

As previously noted, the social-structural factors operating to create the hourly patterns are more readily apparent. As might be expected there is a relatively high level of TV viewing in the evening hours when the day has ended and patients are relaxing before bedtime. However, what might not be expected is the high level of viewing between the hours of 8 and 9 AM and 4 and 5 PM. The latter hour has the highest median number of viewers for the entire day. The large number of viewers at these two times cannot be just a function of having more people in the lounges engaged in activities of all kinds because these are not the peak periods for the median number of persons engaged in all other activities. But, the 8 to 9 AM hour is also the daily peak for the median number of persons engaged in Passive, Dysfunctional Intrapersonal activities.

While it is impossible to determine from these data the exact social-structural forces operating to create these peaks in TV viewing and Dysfunctional Intrapersonal activities, it seems likely that they

are a function of the hospital's daily schedule. As noted earlier, some patients begin waking up at 5 AM. They take showers, get dressed, make their beds and attend to other housekeeping chores. By 7 AM almost all have completed this process and the patients eat breakfast between 7 and 8 AM. The hour between 8 and 9 is "dead" time for the patient unless he or she has personal duties to attend to. This is because most structured group therapeutic, educational and recreational activities do not begin until approximately 9 AM when the professional staff (such as psychologists and social workers) organize these activities after reporting for work at 8 AM.

Throughout the day then, depending upon his or her condition and treatment program a patient may participate in educational classes, exercise programs, group or individual therapy sessions, craft classes or many other structured activities. This means that throughout the day patients are moving on and off the ward as they come and go from the structured activities. This process continues until late afternoon when the organized activities cease and the professional staff prepares to go home. The hour between 4 and 5 PM is another period of "dead" time when, unless he or she has some personal matters to attend to, the patient is simply waiting in the lounge for the dinner hour. It should be noted that the early morning and late afternoon periods are the times when medication is dispensed.

The two rapid drops in the median number of persons watching television between 11 AM and Noon and 5 and 6 PM can also be explained by the hospital's schedule. It is during these two hours that lunch and dinner are served.

These data allow us to only determine <u>when</u> the patients are watching television or engaging in other activities and not which patients are participating in these activities. Nevertheless, speculation as to

when the different types of patients watch television during the institutional day, combined with the knowledge of the hospital's daily schedule, may also help explain some of the social-structural forces operating in this environment.

As with most mental hospitals, the institution where these data were gathered has a patient population that can loosely be categorized as being made up of those considered chronic, those considered acute, and those considered to have passed the acute phase of their illness and are recovering. The chronic patients have often been hospitalized for years, and while they are involved in active treatment programs, they do not participate in many of the "elective" programs offered by the hospital. Consequently, they spend much of their time in ward lounges. The acute patient is most likely to have been recently admitted to the hospital and, for a number of reasons, is most likely to be confined to the ward. As a consequence, this type of patient also may spend more time in the lounge. The third category of patient is the "active" patient who is moving on and off the wards participating in a variety of activities during the day.

This last category accounts for by far the largest percentage of patients in the hospital. But, while the chronics and acutes do not make up a large percentage of the total patient population, they may make up a consistent percentage of those in the lounges during the day. Consequently, any variation in the number of persons watching TV and participating in the other activities may be caused by the active patient who is in and out of the lounge for different periods of time during the day.

This information may help explain why the correlational analysis, for the most part, did not reveal any consistent relationships among TV

viewing and the other social-structural variable clusters. In essence, the chronics and acutes may have a "leveling" effect on the measures that is enhanced by the fact that the patients who are moving on and off the wards are more heterogeneous in terms of lounge behavior. If this assumption is true, then a correlational analysis of these social-structural variable clusters that controls for the type of patient might reveal stronger associations.

In summary, the results of this descriptive study provide new information about the unique environment in a mental hospital. The results provide a better understanding of when television is used during the week and day as well as evidence to suggest the identity of some of the structural forces operating to create viewing patterns. While there is still a great deal more to learn about this environment, mass communication researchers and mental health clinicians can use this information, in combination with the results of other studies, to begin suggesting general types of therapeutic programs involving television in the mental hospital. That is the purpose of the next section of this paper.

Comment on the Therapeutic Potential of Television in a Mental Hospital

Space does not permit extensive discussion of all that is involved in the therapeutic application of television in a mental hospital. Consequently, what follows is a brief comment on two general categories of therapeutic procedures using television, the types of patients that might benefit most from television therapy and when such procedures might be incorporated into the mental hospital routine.

Obviously, the first general category of any therapy involving television is one that takes advantage of existing programming on public and commercial networks and stations. Rubinstein et al. (1978)

discovered that there are isolated examples of this taking place in the 18 New York psychiatric centers they investigated. They report that in these instances existing television programming is used as the focus for reality-oriented discussion groups, other types of discussion groups and behavior modification programs.

It certainly seems plausible that a variety of existing TV programs can be used in a therapeutic manner. For instance, news and informational programs can be used to increase the level of current events knowledge of patients. Previous research by Ostman et al. (1978) indicates this is a real need. Furthermore, attempts can be made to increase the pro-social impact of special programs such as Roots and Holocaust by helping patients develop a context in which to interpret the content. Also, television therapy for patients may capitalize on the often reported functional utility of soap operas and use these programs to help patients develop problem solving skills. Furthermore, television therapy might be used to increase the aesthetic awareness of patients by teaching them techniques for critically analyzing theatrical and musical performances.

But most importantly, it would seem that a prime objective of any therapy involving existing television programming would be to teach patients how to watch television. This is not as frivolous as it might seem. Mental patients, as well as many in the "normal" population, need to become aware that most television programs are dramatized events that infrequently depict reality and perpetuate stereotypes which may or may not reflect desirable personal or social norms.

A second type of television therapy is that which would use specially designed programs to meet the specific needs of mental

patients. Certainly the development of this type of programming is a longer range objective, but in this age of cable systems and video recorders, it is a goal that can be achieved after extensive consultation between communication specialists and mental health experts.

To develop this type of television programming it might be useful to build on the experiences of those who have integrated films into existing therapeutic programs and those who have developed special TV programs for other audiences. For instance, Behymer, Canida, Cooper, Faden and Kahne (1957) investigated the possibility of using mental health films to educate patients regarding mental health concepts and psychiatric practices. They found that films tended to complement and facilitate other therapeutic procedures. A contemporary model of television programming designed for a specialized audience is the Cancion de la Raza project by Mendelsohn (1969, 1971) where educational "soap operas" were developed to meet the unique needs of urbanized Mexican-Americans.

Further research will be needed to identify optimum formats and topics but programming of this type might be used to supplement existing procedures to accomplish several goals. First, such television programs could be used to inform and educate patients about mental illness. Second, such programming could be used to facilitate administrative tasks--such as orienting new patients to the hospital. Furthermore, there are a variety of special topics that deal with problems that are unique to mental patients that could be the subject of special television programming. These include such things as the importance of taking medication, developing personal grooming habits and coping with the problems of reentering the community after a period of hospitalization.

Because the patient population of most modern hospitals is far from a homogeneous group of persons, it may be that therapeutic programs involving television will need to be designed differently for different types of patients. In their survey of New York psychiatric center directors and ward staff Rubinstein et al. (1977) explored the question of different effects of television for different patients. They report that these professionals believe that there are systematic differences among types of patients in terms of the impact of television. They suggest that age, intensity of illness and length of institutionalization may influence how television affects patients. Specifically, the ward staff "perceived television as having positive effects upon geriatric and chronic patients, and essentially negative effects upon acutely ill individuals. Perceptions of television's effects on adolescents were more mixed, with an equal number of respondents indicating positive and negative effects." (Rubinstein et al. 1977, p 16.) Also, they report that while "the directors seem to approve of the educational 'window to the world' television provides for socially deprived, longer term patients, they believe that some of the program content on television is inappropriately stimulating to the acting out, affectively disordered individual." (Rubinstein et al. 1977, p 17.)

Certainly, this would suggest that "television therapy" would not be best for every patient in the hospital. Furthermore, additional research might indicate that even each patient's level of recreational television viewing may need to be adjusted (just like his or her level of medication) to account for individual differences due to age, intensity of illness and length of institutionalization. Certainly this

approach would be consistent with the view of the American Medical Association that television is an environmental health hazard.

Therapeutic programs involving TV could be instituted any time during the day and week in a mental hospital. However, the results of this study suggest that there may be "better" times during the week and day to have patients participate in therapeutic programs involving TV. It seems that the primary factor operating to determine when patients watch television is the daily and weekly schedules of other activities in the hospital. These schedules will vary from hospital to hospital, so an analysis of each hospital's situation would be necessary in order to determine these best times. For instance, in the case of the institution studied for this report, Mondays and Thursdays follow "heavy" viewing periods and, as a consequence, might be good days to schedule weekly therapeutic sessions. Also, the daily schedule of this institution suggests that the early morning and late afternoon would be opportune times for any TV therapy. Simply designing programs that would fit the apparently purposeless viewing going on at this time into a more constructive context would be a start.

CONCLUSION

This study sought to identify the television viewing patterns, as well as the patterns of other activities taking place at the same time, in a mental hospital. The results of this study indicate that there are structural factors operating in the mental hospital to determine peak daily and weekly television viewing times that are not necessarily consistent with those predicted by conventional wisdom. Also, this study has provided a brief discussion on how the results from this investigation can be combined with that of other research to help

clinicians begin designing therapeutic programs involving television in a mental hospital. Hopefully, the results of this study will call attention to the potential benefits of further research. If health communication and mass communication researchers combine their talents with mental health clinicians the goal of comprehensive therapeutic programs can be acheived much sooner. Meanwhile, an additional goal of such professionals should be to identify the isolated examples of therapeutic programs involving television that now exist, evaluate the effectiveness of these programs and work with therapists to improve and expand them.

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Footnote

[1]For those who have difficulty interpreting a series of medians that represent numbers of persons when the medians are less than 1.00, a helpful procedure is to multiply each median by the constant 100.

TABLE 1

Range and Median Number of Persons Engaged in TV Viewing and All Other Non-TV Viewing Lounge Activities by Day of Week and Hour of Day

Day/Hour	N of Observations	TV Viewing Median	TV Viewing Range	All Non-TV Activities Median	All Non-TV Activities Range
Monday	168	2.40	16	.07	8
Tuesday	166	1.68	11	.07	10
Wednesday	169	4.23	15	.09	14
Thursday	181	2.81	13	.05	11
Friday	175	3.18	20	.02	4
Saturday	171	3.92	17	.05	8
Sunday	174	3.82	20	.05	10
5-6 AM	29	0.00	0	.00	0
6-7 AM	66	2.38	16	.00	0
7-8 AM	68	2.13	11	.02	1
8-9 AM	67	4.67	15	.05	3
9-10 AM	72	2.50	14	.08	3
10-11 AM	76	2.60	13	.09	10
11-Noon	55	.46	8	.06	8
Noon-1 PM	71	2.43	15	.06	13
1-2 PM	71	2.25	12	.09	8
2-3 PM	72	2.81	11	.06	5
3-4 PM	68	3.54	10	.09	5
4-5 PM	69	5.13	13	.06	14
5-6 PM	64	2.81	20	.03	3
6-7 PM	71	4.75	20	.05	5
7-8 PM	70	4.75	19	.06	7
8-9 PM	78	3.75	12	.08	11
9-10 PM	69	4.31	14	.05	10
10-11 PM	63	2.50	11	.03	1

TABLE 2

Range and Median Number of Persons Observed Engaged in Reading, Interpersonal Activities, Functional Intrapersonal Activities and Dysfunctional Intrapersonal Activities by Day of the Week and Hour of Day

Day/Hour	N of Observations	Reading		Interpersonal		Functional Intrapersonal		Dysfunctional Intrapersonal	
		Median	Range	Median	Range	Median	Range	Median	Range
Monday	168	.06	1	.09	5	.04	7	.29	10
Tuesday	166	.00	0	.07	9	.03	3	.32	14
Wednesday	169	.02	2	.06	14	.02	2	.14	11
Thursday	181	.01	1	.05	10	.02	9	.19	13
Friday	175	.04	1	.02	4	.02	2	.14	17
Saturday	171	.02	1	.05	7	.03	3	.16	10
Sunday	174	.05	2	.04	7	.01	2	.31	10
5-6 AM	29	.00	0	.00	0	.04	2	.13	4
6-7 AM	66	.00	0	.00	0	.00	0	.17	10
7-8 AM	68	.00	0	.01	1	.00	0	.19	12
8-9 AM	67	.01	1	.05	3	.01	1	.43	17
9-10 AM	72	.01	1	.08	3	.01	1	.32	13
10-11 AM	76	.04	2	.09	7	.03	3	.38	14
11-Noon	55	.03	1	.06	7	.02	1	.12	5
Noon-1 PM	71	.06	2	.06	13	.03	3	.27	11
1-2 PM	71	.07	2	.08	5	.05	9	.20	9
2-3 PM	72	.06	1	.06	4	.06	8	.29	7
3-4 PM	68	.07	2	.09	5	.02	1	.26	7
4-5 PM	69	.02	1	.08	14	.02	1	.28	6
5-6 PM	64	.00	0	.03	2	.01	1	.14	11
6-7 PM	71	.01	1	.05	5	.03	2	.17	10
7-8 PM	70	.00	0	.06	6	.02	2	.20	10
8-9 PM	78	.02	1	.08	10	.04	1	.21	14
9-10 PM	69	.03	1	.05	9	.05	2	.11	8
10-11 PM	63	.03	1	.03	1	.02	1	.07	6

TABLE 3

Spearman Rank Correlation Coefficients for Daily Medians of Number of Persons Observed Watching TV, Reading, and Engaged In Interpersonal, Functional Intrapersonal and Dysfunctional Intrapersonal Activities

	TV Viewing	Reading	Interpersonal	Functional Intrapersonal	Dysfunctional Intrapersonal
TV Viewing		.18	-.41	-.85*	-.71
Reading			-.09	-.05	-.11
Interpersonal				.65	.31
Functional Intrapersonal					.34

All correlations based on N=7.
* $p < .01$

TABLE 4

Spearman Rank Correlation Coefficients for Hourly Medians of Number of Persons Observed Watching TV, Reading, and Engaged in Interpersonal, Functional Intrapersonal and Dysfunctional Intrapersonal Activities

	TV Viewing	Reading	Interpersonal	Functional Intrapersonal	Dysfunctional Intrapersonal
TV Viewing		-.05	.26	.02	.29
Reading			.69**	.56*	.28
Interpersonal				.28	.64*
Functional Intrapersonal					-.16

All correlations based on N=18
* $p < .01$
** $p < .001$